CHAPTER 5:

EVALUATING THE TRANSFORMATION OF MENTAL HEALTH SERVICES IN WASHINGTON

OVERVIEW

The evaluation of the Washington State Transformation *(Partnerships in Recovery)* will follow the evaluation plan originally submitted in Washington State's proposal. The planning activities of the first nine months of the grant have not substantively altered the original plan and the primary components remain in place as originally proposed. Although some minor revisions to components of the plan have been introduced to attain efficiencies not apparent when the proposal was written, the approach remains essentially unchanged. The text that follows outlines the evaluation plan for the State's Transformation, explaining these minor revisions and describing the more detailed evaluation planning leading to the current version of the evaluation plan.

As stated in the original proposal, the primary purpose of Partnerships for Recovery's evaluation will be to provide information useful to managing the Transformation and to hold those involved accountable to the outcomes specified in this proposal. Secondly, the evaluation has been designed to ensure accountability to SAMHSA for performance and outcomes of the Initiative. The proposal stressed the following:

- **The evaluation process will be consumer and family driven**. Consistent with the President's New Freedom Commission on Mental Health, the evaluation plan for system transformation in Washington State ensures that both adult and youth consumers and their families play active roles. Through establishing a Consumer Evaluation Subcommittee and a Family Member Evaluation Subcommittee and through representation on all committees and workgroups, the input of consumers and family members will drive all facets of the evaluation process.
- **A transformed mental health system centers on development of an infrastructure that allows consumers, family members and other stakeholders to monitor progress, evaluate outcomes, and assess the need for mid-course corrections**. Implementing and sustaining large-scale changes in the way state and county agencies do business requires a multi-agency database and a capacity to use data to inform multiple stakeholders and guide implementation.

The evaluation process will have three principle components.

The principle components of the evaluation process include:

1. Development and Implementation of Government Performance and Results Act (GPRA) measures;
2. Collection and reporting of SAMHSA's National Outcome Measures across all agencies engaged in the transformation; and
3. Implementation of a Theory of Change evaluation to assess the overall impact of the Initiative on achieving the six original goals of the President's New Freedom Commission and two goals on employment and housing added by Washington State's Transformation Work Group.

The primary responsibility for the evaluation will remain with the Transformation Grant staff, who will coordinate the work with the primary contractors for this project:

- DSHS, Division of Research and Data Analysis
- DSHS Division of Mental Health Research Division
- The University of Washington, Division of Justice and Health Policy
- The Cecil G. Sheps Center for Health Services Research, University of North Carolina-Chapel Hill

The Transformation effort in Washington State spans many aspects of public heath, requires data and input from multiple cross-agency sources, attempts to incorporate consumers and family members in new ways, and creates new partnerships for evaluation of mental health services in the state. With this ambitious agenda it was decided in the original proposal planning that no one entity could address all evaluation fronts simultaneously. For these reasons, this consortium of state agencies, local and national experts in systems change evaluations, has been assembled for the evaluation effort.

Evaluation Task Group Recommendations

A more detailed level of evaluation planning occurred in April and May 2006. Evaluation was one of six Task Groups established by the Transformation Work Group (TWG). (See Appendix 6 for a list of Evaluation Team members.) While other task groups relied on expertise recruited from the appropriate professional communities, we utilized the existing evaluation team, including the

Family and Consumer Education Team (FACET) members to perform this planning effort for the evaluation. This ensured that consumers and family members were a central part of the critical planning effort, and they were central to the process. The goal of the group was to consider the Transformation activities to date, including the articulation of Transformation outcomes and to further develop the evaluation plan, beyond that articulated in the original proposal. As has been the case for several of the other Task Groups, it is difficult to plan an evaluation until some specific program and policy changes are identified. Following the lead of the other Task Groups, the Evaluation Team articulated a set of five recommendations that would further guide the evaluation effort as specific changes are pursued in the planning and Transformation process:

Recommendation 1

– As part of the Comprehensive State Plan, a logic model should be developed that will guide the ongoing evaluation of the Transformation effort. It should include Transformation goals and activities, inputs and outcomes.

– This logic model would be embedded in the evaluation plan.

Recommendation 2

– The Transformation Workgroup should frequently review data and results produced by the Evaluation Team to inform and guide development, implementation, and sustainability efforts.

– Evaluation Results should be regularly publicized and easily accessible to the general public.

Recommendation 3

– Build the capacity of consumer-run programs to participate in self-evaluation, and to contribute to the Transformation Grant evaluation.

Recommendation 4

– The evaluation should measure both process and outcome changes, and examine both consumer and system level components

Recommendation 5

– The Evaluation Team will develop and submit to the TWG for review an evaluation plan based on the final strategies outlined in the Comprehensive State Plan.

It will be important for the Comprehensive State Plan to prioritize the strategies and put them in sequential order for implementation.

Consumer, Family, and Youth Involvement in the Evaluation

The evaluation process for the Transformation effort provides one of the avenues for investing consumers, youth and family members with decision-making powers over Transformation activities and outcomes. The original proposal identified several mechanisms to accomplish this goal. The original plan was to establish two evaluation subcommittees, one for Families and Youth and one for Adult/Older Adult consumers. These committees will review all proposed evaluation activities and findings to determine if they are responsive to consumer- and family member-identified concerns and address cultural issues. Membership of the two subcommittees will come from individuals nominated by statewide and local consumer and family member groups and by providers. The proposal also identified a FACET that will be integral to all evaluation efforts, and that would participate fully in determining the responsiveness of the Transformation to consumer voice and concerns, recovery, and cultural sensitivity. The original proposal did not clearly differentiate the role of these committees, and was not clear or whether the committees overlapped in membership, scope and responsibility.

Given this ambiguity, the Transformation Staff in consultation with the evaluation partners, formed a single committee, the FACET, and centered the responsibility for consumer and family member involvement in the evaluation with this group. This was done to facilitate progress and to maximize the input of consumers with evaluation professionals early on in the process. The formal definition of FACET is:

> *The team of consumers, family members and youth that participate with research and evaluation professionals on to the MHTP Evaluation Team to conduct required evaluation activities for the grant. FACET membership will be comprised of no less than six consumers as defined above, and the two half time consumers employed by the University of Washington for this project. The total membership of FACET should include no less than four adult consumers and no less than four parents/legal guardians, should contain representatives of both Eastern and Western Washington, urban and rural areas, and represent the ethnic diversity of the state. The contractor shall consult with MHTP consumer staff in selecting members for FACET, and obtain their approval in finalizing membership*

for this group.

FACET team members were named in February 2006 and the team currently consists of 10 consumers and family members. These individuals, the evaluation partners, and MHT staff have been meeting twice monthly since

February 2006, to complete the planning and execution of Transformation activities.

The Evaluation Task Group also planned a series of training events intended to increase the skills and knowledge of consumers and family members regarding the evaluation. Beginning in the second year of the grant, the evaluation team will work with consumer groups, and the consumer network development team to identify evaluation studies that are germane to the concerns of consumers and families and may not be addressed by the main evaluation design. “Mini” contracts will be made available to family and consumer organizations to conduct small evaluation studies on these topics. Up to $10,000 is expected to be set aside each year of the grant, to be made available to consumer groups to directly evaluate their own programs. The evaluation team will be responsible for making funding decisions, with the University of Washington contractors responsible for designing the grant application process.

Together with Partnerships for Recovery staff and other consultants, our goal will be to create multiple roles for consumers and family members in evaluation, to establish roles with significant decision making authority, to actively employ these individuals in the enterprise and to create learning paths and career development opportunities for those interested in this work. This approach to the role of consumers and family members in evaluation represents a significant departure for Washington State, and demonstrates a clear commitment to consumer and family member voice in the Transformation.

Existing Resources and Approaches to Data Collection

Consistent with the President’s New Freedom Commission Report, Washington State has long recognized that persons with serious mental illnesses or serious emotional disturbances may have contact with a broad range of non-mental health settings (e.g., adult or juvenile justice, education, child welfare, vocational rehabilitation, Medicaid). In response to this recognition, and prior to the SAMHSA State Transformation RFA, administrators and policy makers in Washington State recognized the

importance of improving screening and referral processes and coordinating services provided across DSHS. To this end, the state established a centralized Research and Data Analysis (RDA) division within DSHS that has access to and coordinates data from across multiple divisions. RDA has constructed a central research database that matches client service records from sixteen different data sources that record child and adult service, authorization, and management information. This technology allows RDA to record the DSHS services used by children and adults who are mental health consumers over time, the cost of those services, contact information, and consumer demography. This central research data warehouse, known as the Client Services Data Base, or CSDB, is then used to provide data for service integration initiatives across the department. The development of the CSDB is critical to creating the foundation for present and future system transformation. With additional enhancements, it will play a critical role in continuous quality improvement feedback and provide information to support the management of Transformation.

In addition to these data, the Mental Health Division of DSHS routinely collects the following data to monitor and analyze the performance of the Washington State mental health system. These data come from a combination of the following five data systems for mental health services and surveys:

- The Mental Health Division Consumer Information System
- The State Psychiatric Hospital data base Health Integrated Information System
- The Medicaid Management Information System payment database
- The Mental Health Statistics Improvement Project, Youth Services Survey, the Youth Services Survey for Families; and the Adult Consumer Survey
- The Department of Social and Health Services, Research and Data Analysis (RDA) Client Services Database (CSDB; described above)

The survey data is based on statewide surveys conducted by the Washington Institute for Mental Illness Research and Training (WIMIRT) for the Mental Health Division. Copies of the survey reports are available at the Mental

Health Division's website
http://www1.dshs.wa.gov/Mentalhealth

or on WIMIRT's Webpage
http://depts.washington.edu/wimirt/Publications.htm.

Information and Data Infrastructure Enhancements Planned

The Transformation Grant allows expenditure of funds for a number of infrastructure enhancements. Data infrastructure enhancements will be crucial to the evaluation of the Transformation, and these enhancements will constitute a key activity in transformation work at the policy, practice and evaluation activities over the life of the grant. Washington State will implement an array of enhancements to Washington's information infrastructure that are designed simultaneously to support the evaluation, guide the Transformation process, and provide information and accountability to consumers and policy makers. Elements of this Infrastructure will include:

- Expansion of the RDA Research database to include additional outcome measures, targeted to provide reporting on the SAMHSA National Outcome Measures and on elements of the GPRA related to direct consumer outcomes.
- Expansion of the consumer satisfaction surveys to include a greater range of outcome measures and to survey mental health consumers who are served by non-MHD systems.
- Implementation of additional surveys to track population and consumer trends in attitudes toward mental illness, stigma, help-seeking behaviors, consumers' perceptions of transformation activities and population-level outcomes.

Data infrastructure enhancements are allowable Transformation Grant expenditures. Although not directly a part of the program evaluation budget, the enhancements planned will be critical to the overall success of the evaluation. Key enhancements underway, in planning stages, as well as broader enhancements being considered, are outlined below.

Specific Data Infrastructure Enhancements Planned—

The Mental Health Transformation Grant will support, over the life of the grant, a significant expansion of DSHS data infrastructure through the development of new data sources, data tables, outcome measures, and reporting processes. Infrastructure development will include:

Core Infrastructure Changes Are Underway

- Processes to capture on an ongoing basis new information (both internal and external to DSHS) on the **use of and need for mental health services,**
- Processes to capture on an ongoing basis new **client outcome data,**
- New tools to measure **quality of mental health services** provided,
- New analyses to measure the **impact of mental health services on client outcomes**, and
- New **reporting processes** to meet grant and program requirements.

The activities in the first project year ending September 30, 2006 include:

1. Developing new longitudinal client-level RSN service tables organized around State Plan mental health service modalities.
2. Developing new longitudinal client-level medical claims diagnosis tables organized around RSN access-to-care standards.
3. Developing longitudinal client-level data tables capturing indicators of need for mental health services from new source systems:
   a. Medical Assistance Healthy Options encounter data,
   b. Economics Services Administration Barcode incapacity data, and
   c. Aging and Disability Services Administration CARE functional assessment data.
4. Identification of non-MHD service categories in existing DSHS data sources that reflect the provision of and/or need for mental health services; development of longitudinal client-level data tables summarizing these service encounters.

Data Infrastructure Enhancements Planned—-Data Needs Outside DSHS for Mental Health Transformation Monitoring and Evaluation

Several questions cannot be answered at all with the current system of data silos.

- How many low-income consumers are we serving overall, across all government agencies?
- How much are we (government) spending on their mental health services?
- What mental health service modalities are they receiving from government?
- Are they receiving government-sponsored help with employment, job training, and housing?

To answer those questions, we need to match consumers receiving mental health services across agencies – especially the other TWG agencies. Currently, we match within the DSHS, but not across the other agencies.

As a next step we need to gather information on the mentally ill persons served, the mental health service modalities provided, costs and dates, from the following state agencies, other government entities and/or programs and services:

- Health Care Authority (requires analyzing encounter data)
- Department of Veteran's Affairs
- Department of Corrections (Prison data)
- City and County Jail data (through the new WASPC data or through our 1290-related data)
- Tribal clinics and Indian Health Services
- Veterans Administration (federal)
- Medicare-Medicaid Dual Eligibles (need the Medicare services)
- Public Schools (if possible)
- Charity hospital care from Comprehensive Hospital Recording System
- Medicaid Management Information System (Drug Pharmacy Formulary)

Data Infrastructure Enhancements: Anticipated Activities in Years 2 Through 5

In subsequent years we anticipate using MHTP resources for the following purposes:

- Ongoing maintenance of the new data tables developed in the first year of the grant.
- Developing longitudinal client-level data tables capturing stability in housing and living arrangements using homelessness and household composition information from the Automated Client Eligibility System.
- Developing longitudinal client-level data tables capturing employment outcomes measured in Employment Security Department earnings data.
- Developing longitudinal client-level data tables capturing standardized measures of access and quality of care that can be derived from administrative data; for example, specific HEDIS measures including quality of psychotropic medication management and follow-up after hospitalization for mental illness.
- Developing access to student-level school outcome data maintained by the Office of the Superintendent of Public Instruction.
- Developing mental health treatment need indicator tables from CAMIS (Children's) and CATS (JRA) information systems.
- To the extent feasible, developing data tables other data sources external to DSHS such as the Veterans Administration, local jails, and housing programs.
- As requested by project staff to support Transformation Grant activities, performing analyses and reporting information describing medical service use, service need, and client outcomes
- Providing longitudinal client-level data tables, documentation, and consultation to the Mental Health Transformation Grant evaluation team

Transformation Evaluation Activities

The grant team will expand current data and evaluation capabilities to address GPRA indicators as well as SAMHSA's National Outcome Measures (NOMS) to assess overall system performance. The GPRA indicators will be

collected, managed, analyzed, interpreted, and reported to monitor, guide and evaluate the process of the evolving Transformation. The collection, management, analysis, and interpretation of the NOMS will assess the impacts of the evolving transformation (i.e., who, what, when, where, and how) on individual consumers and their families. These activities are described below.

Development and Reporting of Government Performance and Results Act (GPRA) Measures

The following steps will be taken to ensure Washington State's ability to collect and report on the GPRA measures:

Step 1: A GPRA workgroup will be convened from the membership of the Evaluation Team.

Step 2. With MHD, RDA, and MHTP staff leadership, the GPRA Workgroup will develop a comprehensive plan to measure and report required GPRA measures and to propose GPRA measures unique to the state of Washington.

Step 3. The GPRA Workgroup will submit the recommended GPRA measures, annual performance targets, and budget implications, and make a recommendation to the TWG.

Step 4. The TWG will finalize the GPRA measures and approve procedures to collect and report on the measures. These will then be submitted to the SAMHSA Project Officer for review/approval.

Step 5. GPRA and related performance measures will be reviewed by the Evaluation Team and at regular TWG meetings. They will be modified, if needed, by the TWG using the process described in the steps above, in coordination with SAMHSA Project Officer and the coordinators of SAMHSA's national field evaluation.

These steps will allow the Partnerships for Recovery to monitor the process of the Transformation using GPRA outcomes for all six of the goals of a transformed mental health system as outlined by the President's New Freedom Commission on Mental Health. GPRA outcomes will be collected and reported as required by SAMHSA.

Initial GPRA Measures Plan

Because SAMHSA's cross-site evaluation contract has not been finalized, we cannot define precisely how we will collect GPRA data for the project. We must await SAMHSA's final instructions before proceeding. However, the Evaluation Guidance document provided by SAMHSA does permit development of an initial GPRA data collection plan. Our initial plan is presented as a draft below.

The seven required GPRA measures are:

1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan.
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan.
3. Percentage of financing policy changes completed as a consequence of the comprehensive Mental Health Plan.
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan.
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.
6. The number of consumers and family members who are members of statewide consumer– and family–run networks.
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan.

Washington State's initial plan to operationalize and collect these data is contained in Table 1 beginning on the following page.

TABLE 1 - GPRA MEASURES

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
1. Percentage of policy changes completed as a consequence of the Comprehensive Mental Health Plan	Require participation of all agencies in partnership with the Mental Health Transformation Project to report the percentage of all policy changes as a result of the approved strategies by the TWG	GPRA Monthly Monitoring Report Who is your WAC Coordinator/or P&P person? Any RCW/WAC/P&P changes in period?	
2. Number of persons in the mental health care and related workforce who have been trained in service improvements recommended by the Comprehensive Mental Health Plan	Require all agencies in partnership with the Transformation Project report the number of persons and related workforce who have been trained in service improvement recommended by the Comprehensive Mental Health Plan	Listing of Training Events By events, sign in sheets Count of participants by: Demographics Consumer status Employed by: Others First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training	
3. Percentage of financing	All Require all agencies in	GPRA Monthly Monitoring Report	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
policy changes completed as a consequence of the Mental Health Plan	partnership with the Transformation Grant to report the percentage of financing policy changes completed as a consequence of the Mental Health Plan	1. Who is your WAC Coordinator/or P&P Person? 2. Any RCW/WAC/P&P changes in period?	
4. Percentage of organizational changes completed as a consequence of the Comprehensive Mental Health Plan (includes interagency agreements)	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	3. Are there any organizational changes relevant to CMHP in period? 4. Are there any MOU's changes relevant to Mental Health in period?	
5. The number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan	MHTP staff and the Evaluation Team will research the number of organizations that regularly obtain and analyze data relevant to the goals of the Comprehensive Mental Health Plan.	5A. Is your organization regularly collecting data relevant to the CMHP? 5B. Is your organization regularly analyzing data relevant to the goals of the CMHP? Develop a monitoring tool to obtain information from: **State Level** State Agencies Regional Level Regional Support Network	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **<u>Consumer Level</u>** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations Develop a Monitoring Tool to obtain information from: **<u>Local Level</u>** State Administrators Regional Support Network Local Providers	
6. The number of consumers and family members who are members of Statewide consumer - and family – run networks	MHTP Staff will establish a list of consumers and family members who are members of statewide consumer and family – run networks.	Listing of all statewide consumer and family member organizations. For each: **Roster of membership** **Count of participants by**: Demographics	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Consumer status Employed by etc. Others…. First example is the CTP (Community Transformation Partnership) Recovery and Resiliency Training Develop a monitoring tool to obtain information from: **Consumer Level** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	
7. The number of programs that are implementing practices consistent with the Comprehensive Mental Health Plan	All agencies in partnership with MHTP are required to report the percentage of organizational changes completed as a consequence of the Mental Health Plan	Develop a Monitoring Tool to obtain information from the **Local Level** State Administrators Regional Support Network Local Providers Develop a monitoring tool to obtain information from: **State Level** State Agencies	

Required GPRA Measures	Strategies	Specific Measures Proposed	Staff assigned and responsibilities
		Regional Level Regional Support Network Consumer Organizations Other Non-Profit Organizations Develop a monitoring tool to obtain information from: **<u>Consumer Level</u>** PAVE, NAMI, SAFE, AND NEW CENTURY Coalition, CTP and those yet to be developed statewide organizations	

Operational Definitions on how to count GPRA Measures will be collected in Washington State

For Policies and Procedures that change in the grant period, number that:

1. Change as a direct result of Comprehensive Mental Health Plan (mandated change)
2. Change associated with Comprehensive Mental Health Plan
3. Change results indirectly from the Comprehensive Mental Health Plan
4. Complementary change that might be enhanced by CMHP

$$\% = \frac{\text{Numerator}}{\text{Denominator}}$$

(N) Count of:
1. RCW
2. WAC
3. State Agency Policy
4. Local Policy

(D) Count of: Policies related to Mental Health within each administration: (total of 1, 2, 3, and 4))

Levels:
1. Governor – State Initiatives
2. State Agency Secretary
3. DSHS Administration Assistant Secretary
4. Division Director
5. Local policies (broadly speaking)

Scope: Only TWG Agencies Representative – Administration/Division

National Outcome Measures (NOMS)

In addition to the GPRA Infrastructure Indicators, the RFA specifies that improvements in State performance on the SAMHSA NOMS will be expected as a long-term result of the grant program. The NOMS are listed below.

1. Decreased mental illness symptomatology/increased level of functioning
2. Increased or retained employment and school enrollment/school attendance
3. Decreased involvement with the criminal justice system
4. Increased stability in family and living conditions
5. Increased access to services/number of persons served

by age, gender, race and ethnicity

6. Decreased utilization of psychiatric inpatient beds/readmission to a State psychiatric hospital at 30 and 180 days
7. Increased social support/social connectedness
8. Increased positive reporting by clients about outcomes
9. Increased cost effectiveness
10. Increased use of evidence-based practices

An important limitation of the URS data is that the NOMS are reported only for people served by the State Mental Health Authority (SMHA). A critical concept of Transformation is that all agencies, and not just the SMHA, should participate in improving the accountability, capacity, and quality of services for people with or at risk for serious mental illnesses or serious emotional disturbances. In keeping with this vital concept, to most effectively measure the impact of transformation on client outcomes, NOMS data must be collected from all relevant agencies.

Specifically, Washington State will expand its data collection strategy to routinely collect NOMS data from all identifiable service recipients in Washington State, not just those served by the Mental Health Division. We will begin this work by including in our first year survey, all adults with mental health diagnoses being served in all eleven administrations of DSHS. We will expand the scope of NOMS surveying in the Years 2 through 5 to include children and family, and those hitherto unknown to DSHS, but who have identified mental health problems.

Recovery and Resilience

A requirement that states measure and report recovery and resiliency was issued in SAMHSA Guidance for the Evaluation of Transformation. That document specifically stated:

> *In order to determine whether transformation has met its goal of facilitating recovery, the national evaluation will help each SIG State to select and use one recovery outcome instrument and one service system recovery-facilitation process instrument to measure their recovery results. We would expect substantial consumer involvement in selecting the recovery measures and in collecting data on recovery. The*

national evaluation will also examine whether corresponding information on resilience can be captured.

As with the GPRA and NOMS data, we would not expect to see measurable effects on the recovery and resilience measures immediately. Most States are not currently quantitatively assessing recovery, and significant data infrastructure development will be necessary in order to institutionalize these measures Statewide. Moreover, our transformation theory predicts that the recovery-orientation of a system will follow institution of the infrastructure changes, which will take some time to implement. We would not expect to see measurable change in the recovery-oriented service systems measures, therefore, until at least the end of year 3 of the grants. Changes in client-level recovery outcomes may not occur until after the grants have ended.

The evaluation team in Washington State decided in the first year of the grant to pilot test the Recovery Oriented System Indicators, one of the recovery measures listed in the compendium offered by HSRI. We have completed a first year pilot of that instrument, found it to be of value, and will make the case that it serve as an acceptable measure of recovery for Transformation States. A report of those findings will be available from project staff in the near future.

Resource Inventory and Needs Assessment

The Resource Inventory and Needs Assessment completed as part of the Evaluation Team's first year of work is included in Appendix 2. That detailed report used multiple methods to identify need and resources available in the state, and has many uses for planning transformation efforts. In terms of evaluation, the principle findings from this report serve to refine the focus of the evaluation, and will constitute place markers for the logic model to be developed. Principal findings from that study fell into four categories:

1. **Expand access to mental health care, to reduce unmet need and to ensure that consumers are served when the problems first manifest themselves.**
    - This may include changing benefit designs to maximize federal match and get more matching dollars, and working to maximize third party reimbursements. Should also include reducing and

simplifying the record-keeping burden for providers, which would save funds throughout the system.
- May also include closing hospital wards to transfer some funds into community services.
- It may also mean some new state funds, since it seems unlikely that the above steps will save enough in the short-term to serve twice as many people as DSHS is serving now.

2. Change community treatment options for all consumers to emphasize recovery, consumer choice and improved outcomes.

- Attend to cultural and geographic subgroups here as well as consumer choice generally – one set of services does not fit all consumers.
- This set of changes alone should improve recovery outcomes and may generate cost offsets in psychiatric hospitalizations, medical costs, and criminal justice costs.

3. Reduce stigma and improve public knowledge about mental illness, treatment options and recovery.

- This is important for every group of consumers – it may be particularly important for people with co-occurring health problems, people who are homeless or in jail or prison, and children and youth.
- This should improve recovery outcomes – it may also enhance potential cost offsets in psychiatric hospitalizations, medical costs, long-term care costs and criminal justice costs.

4. Integrate and coordinate services more effectively for clients with multiple problems.

- This is very important for the wellbeing of consumers, more than half of whom report encountering discrimination and stigma.
- This too is important because the first treatment and referral source for mental illness will always be families and friends in the community.
- Community and family members need to know how common mental illness is, that effective community based treatment is available, where it is, and that it works!

Theory of Change Evaluation

The Evaluation Team will utilize all that was learned in the first project year to develop a complete logic model, with activities, timelines, and benchmarks clearly specified. Then in Years 2-5 the Evaluation Team will conduct an

impact evaluation using a theory of change evaluation approach. The evaluation will assess long-term outcomes addressing the eight goals adopted for this project (the President's six New Freedom goals, plus the employment and housing goals adopted in Washington State by the TWG. The areas of need identified through the Resource Inventory and Needs Assessment will also be essential components of an articulated theory of change for the Transformation.

Elements to consider. An integral part of the logic model/theory of change for this evaluation will consider the elements suggested by SAMHSA in their Evaluation Guidance Document, for the focus of the model. The following were suggested by SAMHSA as likely candidate processes that might contribute to successful organizational change in Transformation. Each will be carefully considered in constructing the model:

- leadership
- workforce competencies
- workforce training and development efforts
- effectiveness of incentives
- organizational readiness and culture
- interagency policy and standards alignment
- integration of mental health-related data across agencies
- performance indicators
- effectiveness of quality assurance mechanisms
- consensus building among stakeholders
- goal achievement
- needs assessment
- interagency collaboration (e.g., number of meetings/conference calls among diff agencies for each goal)
- barriers encountered and how resolved (e.g., see identified barriers from the New Freedom Commission Final Report, Executive Summary, p. 23)
- resource flexibility
- contract expectations
- values orientation
- public/private partnership/relationship
- impact of economy and financing cuts on MHT efforts
- interim steps in making infrastructure changes, e.g., meetings held, agreements reached, etc.
- impacts of MHT on other agencies and impacts of other agencies on MHT; how MHT is taking its place in the consortium of other interests

- inclusion of consumers in above areas

The four principle areas of findings from the Resource Inventory and Needs Assessment (see Appendix 2) will also constitute key elements (inputs, outputs, processes in the construction of the model.

Focusing on many of the processes above, the following issues will be addressed in the logic model that will serve as the articulated theory of change for this project. That document and model will then guide evaluation efforts over the life of the evaluation. Among the questions to be addressed, the listing below is offered as an initial scope and purpose of the evaluation. Finalization will occur after the TWG and participating agencies and stakeholders come to consensus about the directions that Transformation will take. Thus the suggested topics below are preliminary:

1. ***The need for mental health care.*** How many people have been screened or served somewhere in DSHS in ways that indicate a "need" for mental health services? What is their age, gender, race, ethnicity and location?
2. ***Mental health service use and costs across systems***. How many consumers needing treatment used mental health services from DSHS? How many from MHD, how many from other parts of the agency? Were the rates and patterns of mental health service use different for different subgroups of people? What kinds of mental health services were used, and what did they cost? How many consumers needing treatment accessed services through non-mental health settings? How well were their needs and preferences met?
3. ***Mental health service cost offsets***. How do non-mental health costs across DSHS compare for those who received various sorts of mental health services, including "no treatment." Are there state costs to NOT serving people, which could be used to expand treatment?
4. ***Mental health service outcomes for consumers and families***. How did various groups of people needing and/or receiving mental health treatment fare in their daily life? How do the groups compare in employment and wages, school enrollments and success, arrests and convictions, and use of medical care? How do consumers and family members feel about the way they were served? Did they report being

involved in individualized planning for their services and supports?

Sound quasi-experimental designs, econometric analyses, multi-level modeling and structural equations will be used to answer critical questions about the macro-level impacts of mental health transformation. The questions include but are not limited to:

- How do the mental health outcomes for child and adult consumers compare before, during, and after the transformation?
- How do community outcomes for mentally ill persons detained in jail (e.g., public health and public safety) compare before, during, and after the transformation?
- What are the intersystem effects of the transformation with respect to point-of-service entry (i.e., irrespective of entry point, do consumers get appropriate services?), information sharing and accountability among agencies involved in serving multiple system users, and the alignment of policies and procedures across multiple systems (i.e., criminal justice and Medicaid)?
- What are the costs of these various transformation efforts? Are cost-efficiencies realized from expanded service delivery and in what sectors?
- What regional differences are observed, and how do these relate to regional demographic characteristics, service configurations, funding arrangements, and other ecological factors.

Feedback and Continuous Improvement

The Evaluation Team (with the consumers, family members and youth an integral part), will report, evaluate, and synthesize evaluation findings on an ongoing basis to the TWG throughout the Transformation process and beyond. These findings will be disseminated in series of reports, presentations, and web mediums among consumers, family members, advocacy groups, key stakeholders, administrators, and other constituents in order to facilitate dialogue about the Transformation's processes and impacts. This dialogue will be used to re-shape, re-focus, and modify the Transformation.